88-204

NO. _____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a state.

2. Whether the Eleventh Amendment can be negated by mechanical application of the rule of *Ex Parte Young* to permit relief against state officials, even if they have relied in good faith on specific judicial and administrative precedent.

3. Whether a facial challenge to a state Medicaid regulation under 42 U.S.C. § 1983 may be brought without the bar of any statute of limitations.

4. Whether a federal court should intervene in a state's comprehensive system for administrative and judicial review of Medicaid provider disputes, particularly where the plaintiffs have never attempted to use that system.

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The Commonwealth of Virginia ("the Commonwealth") whose officials were Appellants below, hereby petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this matter.[1]

I.
OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, dated February 22, 1989, is reported at 868 F.2d 653 and is also

[1] Appellants in the Court of Appeals and defendants in the District Court are the Governor and the Secretary of Health and Human Resources of the Commonwealth, as well as the Director of the Department of Medical Assistance Services and members of the Virginia Board of Medical Assistance Services. Although the Governor and Secretary were initially sued in their individual capacities, they were dismissed in such capacities by consent of the plaintiff and by order of the district court on May 2, 1986. They are all now sued only in their official capacities. Plaintiff in the District Court and appellee in the Court of Appeals is the Virginia Hospital Association, a Virginia corporation. In the Court of Appeals, 27 states filed or joined an amicus brief in support of the Commonwealth on one issue. The American Hospital Association filed an amicus brief in support of the Virginia Hospital Association on that same issue.

set forth in Appendix A. The March 22, 1989 order of the Court of Appeals denying the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc* is set forth in Appendix B. The March 29, 1989 order of the Court of Appeals denying a stay of its mandate is set forth in Appendix C.

The order and opinion of the United States District Court for the Eastern Division of Virginia, Richmond Division, dated May 18, 1988, are unreported and are set forth in Appendix D.

II.
JURISDICTION

The jurisdiction of this Court to issue a writ of certiorari in this case is grounded upon 28 U.S.C. § 1254(1).

III.
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves the application of the Eleventh Amendment to the United States Constitution, which provides:

> The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state.

While this case also involves the construction and application of a number of provisions of Title XIX of the Social Security Act (42 U.S.C. § 1396, et seq.) ("the Medicaid Act"), the most important provision is 42 U.S.C. § 1396a(a)(13)(A), which reads, in pertinent part, as follows:

> A state plan for medical assistance must . . . provide . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access . . . .

IV.
STATEMENT OF THE CASE

A.
Procedural Background

On March 19, 1986, the Virginia Hospital Association ("VHA") filed this suit in the District Court challenging the validity of the regulatory methodology whereby the Commonwealth's Medicaid Program, which is administered by the Virginia Department of Medical Assistance Services ("DMAS") pursuant to Chapter 10, Title 32.1 (§ 32.1-323, *et seq.*) of the Code of Virginia, establishes reimbursement rates for participating hospitals. The suit challenges the validity of the mechanism ("Reimbursement System") whereby DMAS sets prospective *per diem* rates for inpatient hospital care of Medicaid patients, as well as the validity of the regulations prescribing procedures for the filing and processing of appeals ("Appeals System") by hospitals not satisfied with their prospective rates.

On September 22, 1986, the District Court dismissed the complaint. It ruled that VHA, being in privity with one of its member hospitals which had been a plaintiff in earlier litigation in the same court on the same subject, was collaterally estopped from bringing this action by reason of the earlier unfavorable ruling in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985).

On appeal, the Court of Appeals reversed. *Virginia Hospital Association v. Baliles*, 830 F. 2d 1308 (4th Cir. 1987).

Upon remand, the Commonwealth moved to dismiss on eight jurisdictional grounds. The District Court denied the motion, but on May 18, 1988, certified these eight issues to the Court of Appeals for interlocutory appeal. The Court of Appeals on July 27, 1988, granted that appeal. On February 22, 1989, it upheld the ruling of the District Court and on March 22, 1989, denied the Commonwealth's petition for rehearing and suggestion for rehearing *en banc*. On March 29, 1989, it denied a stay of its mandate pending the filing of this petition.

B.
Factual Background

The Commonwealth, like all states, participates in the national Medicaid Program pursuant to the Medicaid Act. As noted above, DMAS is the agency of the Commonwealth which has been charged since 1985 with the responsibility for administering that program. Under

the program, DMAS has promulgated implementing regulations known collectively as the State Plan.

Until 1981, the Medicaid Act required states to pay participating hospitals the "reasonable cost" of inpatient services to Medicaid patients. In 1982, in response to the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Commonwealth, like many other states, adopted the Reimbursement System as an amendment to the State Plan to allow the use of prospective reimbursement for hospital services, effective July 1, 1982. Under the Reimbursement System, cost medians from 1981 data were used as a starting point and an inflator, the Consumer Price Index ("CPI"), was used to inflate such medians for subsequent years.

In 1983, one of VHA's member hospitals brought a challenge to the Reimbursement System. *Mary Washington Hospital, supra.* In that case, the District Court on January 4, 1985, upheld the legality of the Reimbursement System in its entirety, except for its distinct appeals mechanism. The District Court ordered the Commonwealth to promulgate a new appeals mechanism. That was done and the new Appeals System was adopted by DMAS in August 1985, and approved by the federal Health Care Financing Administration ("HCFA") on March 3, 1986. Subsequently, the District Court upheld the legality of the Appeals System by order dated April 21, 1986. No appeal from this order was taken.

With the exception of two replacements of the CPI with different inflators and other minor changes not relevant to this litigation, the Reimbursement System remains unchanged since its original promulgation in 1982. The Appeals System has not been amended at all since its 1985 promulgation. None of the over 100 member hospitals of VHA has pursued an appeal under the Appeals System, although they have preserved their right to do so.

V.
JURISDICTION OF THE UNITED STATES DISTRICT COURT

The United States District Court for the Eastern District of Virginia, Richmond Division, assumed jurisdiction of this matter, in part pursuant to 42 U.S.C. § 1983. Whether it should have done so is one of the issues in this appeal.

VI.
REASONS WHY THE PETITION FOR CERTIORARI SHOULD BE GRANTED

INTRODUCTION

Rule 17.1 of the Rules of this Court provides that a writ of certiorari will be granted only when there are special and important reasons therefor. Rule 17.1(c) lists among such reasons a decision by a federal court of appeals on an important question of federal law which has not been, but should be, decided by this Court.

This case presents four such questions, any one of which meets the foregoing criterion. Recent federally-mandated growth of state Medicaid programs, rapid inflation of health care costs and the growing needs of an elderly indigent population have combined to create an unprecedented demand for Medicaid services. As state Medicaid budgets grow, litigation between providers and the states has increased.

In this context, the Court of Appeals has opened the federal courts to providers of health care to litigate reimbursement disputes against states under the Reconstruction era federal civil rights statutes. In so doing, it has placed the financial interests of providers on an equal footing with the civil rights of the sick and needy. It has further allowed a state to be stripped of its Eleventh Amendment immunity by the simple process of suing its officials -- even those whose good faith has not been and cannot be questioned. It has removed any statute of limitations bar from a facial challenge to Medicaid reimbursement regulations. Finally, although federal law gives the states the lead role in the national Medicaid Program, the Court of Appeals has allowed federal courts, essentially on demand, to hear disputes designed for state resolution.

Given this result, the interest of 27 states in joining the Commonwealth as amicus below is understandable. Final and timely resolution of the important national issues of both law and policy presented in this appeal will define the future scope and direction of Medicaid provider litigation. Equally important, it will determine whether the national Medicaid crisis will be exacerbated by the unnecessary federalization of legal disputes between the states and providers regarding financial reimbursement that can be ably and fairly adjudicated by state courts.

A.
By Treating Health Care Providers As The Intended Beneficiaries With Enforceable Rights, the Courts Below Have Restructed The Medicaid Program

This case presents an important question that will determine the future direction of Medicaid programs nationwide. This Court agreed to decide the same issue in 1987, but did not address the merits because of changes in the underlying facts that rendered the case under review moot.[2] The question presented is whether a health care provider, such as a hospital, has rights under the Medicaid Act that are enforceable privately against the states in federal court.

The Court of Appeals correctly noted (App. at A-5) that the Medicaid Act does not confer an express right of action on health care providers. Nonetheless, the Court came to the conclusion that Congress intended such providers, when seeking revised Medicaid rates, to have an implied right of action against the states, enforceable under 42 U.S.C. § 1983 ("§1983").

In *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987), and earlier in *Cort v. Ash*, 422 U.S. 66 (1975), this Court instructed federal courts how to determine whether a particular plaintiff is entitled to sue under § 1983 when, as here, the underlying federal statute on which the claim is based is silent. The primary focus of that inquiry is whether the plaintiff, here an association of hospitals, is part of the special class for whose benefit the statute was enacted.

In answering that question in the affirmative, the lower courts in this case found that hospitals are among the intended beneficiaries of the Medicaid Program, a national joint federal/state welfare program designed to pay medical expenses for the eligible poor. For a rationale, the decisions below (App. at A-7,8; D-4, 5) simply point to lengthy requirements in the Medicaid Act prescribing the content of state plans and conclude that Congress meant these requirements to be enforceable by providers directly against the states.[3]

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[2] *Coos Bay Care Center v. Oregon Department of Human Resources*, 803 F. 2d 1060, (9th Cir. 1986), *cert. granted*, 107 S.Ct. 1970 (1987), *judgment vacated and remanded on the issue of mootness*, 108 S.Ct. 52 (1987).

[3] Participation in the Medicaid Program is voluntary, except as to those providers who have contracted to participate for other reasons, such as the valuable consideration received under the Hill-Burton program. 42 U.S.C. § 291, *et seq.* Since providers are not compelled to participate in the Medicaid Program, there is no reason to imply enforceable rights for them other than those created by provider contracts. Such contracts, voluntarily renewed on a regular basis, obligate the provider to accept program payments.

Such conclusory analysis is not consistent with Congressional intent or this Court's decisions. The original legislative history of the Medicaid Act contains no evidence that Congress intended the Medicaid Program to benefit health care providers. S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U. S. Code Cong. & Admin. News 1943[4]. To the contrary, the legislative record shows conclusively that the growing and increasingly complex provisions of the Medicaid Act -- and in particular 42 U.S.C. § 1396a(a)(13)(A) reprinted in Part III, *supra* -- are designed to guide HCFA in its continuous oversight and review of state plans and programs. A correct reading of that section and the underlying regulations (42 C.F.R. § 447.250 *et seq.*) makes clear that the only obligation of participating states with respect to hospital reimbursement is to make findings and assurances to the Secretary (HCFA) and to obtain the approval of the latter as a pre-condition to federal funding. Both VHA and the lower courts rely upon only a portion of the statute; in so doing they reach an untenable result.

Over a decade ago, Congress mandated and, within a year thereafter, repealed a requirement that states waive their Eleventh Amendment immunity from suits by hospitals over reimbursement as a condition of participating in the federal Medicaid Program -- the precise subject of this litigation. At the same time, concerned that providers would not have a forum in which to raise such issues, Congress specifically directed HCFA to develop a mechanism for adjudication of disputes concerning Medicaid reimbursement rates. S. Rep. No. 1240, 94th Cong., 2nd Sess, *reprinted in* 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. What resulted is the present federal regulation requiring state appeals procedures such as the Appeals System. *See* 42 C.F.R. § 447.253(c).

The decision of the Court of Appeals expressly discounts the role and degree of federal oversight in the Medicaid Program. (App. at A-10). Given the extensive system of plan approvals, audits and policy review currently in place, the better interpretation is that Congress -- consistent with this Court's decision in *Wright, supra*, -- has put in place a comprehensive framework of federal enforcement that *forecloses*, rather than implies, a private cause of action.

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[4] The self-explanatory stated purpose of the Medicaid Act is:

> For the purpose of enabling each State as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .

42 U.S.C. § 1396.

Despite the weight of authority indicating that Congress intended states not to be subject to federal suits by providers under the Medicaid Act, the decisions below reached the opposite result. Providers are now free either to sue a state in federal court or to pursue an appeal under the state appeals procedures. This creates a dual system of review never intended by Congress and inconsistent with the states' orderly administration of their Medicaid programs. It threatens to flood the federal courts with suits that can and should be resolved in state administrative or judicial forums.[5]

Thus, the lower court decisions in this case have, by judicial fiat, turned the Medicaid Program, a welfare program for needy patients, into an entitlement program for health care providers and have thereby duplicated existing state administrative procedures mandated by Congress. This result is not consistent with the exercise of cooperative federalism through the operation of a Medicaid Program in which the states have the laboring oar. This Court must prevent the growth of unproductive federal litigation by providers and thereby avoid the threat of serious harm to this critical welfare program, the only source of medical assistance for many indigent and elderly citizens.

B.
Mechanical Application Of This Court's Ex Parte Young Decision Has Improperly Negated The States' Eleventh Amendment Immunity

This case also presents an issue central to the continued vitality of the federal system: the extent to which the Eleventh Amendment immunity of the states can be eroded by an unnecessarily broad reading of the doctrine first enunciated in *Ex Parte Young*, 209 U.S. 123 (1908).

The Eleventh Amendment bars suit in federal court against an unconsenting state brought by its own citizens, as well as citizens of another state. *Papasan v. Allain*, 478 U.S. 265, 276 (1986); *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 238 (1985); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 109 (1984). Unless the Commonwealth has waived its immunity by expressly consenting to this

[5] As indicated in note 1, *supra*, 27 states supported the Commonwealth through an amicus brief in the Court of Appeals. Their principal concern was that a result such as that reached by the Court of Appeals will render superfluous the provider appeals systems developed by each state, will hamper the orderly administration of the various Medicaid programs and will intrude into the states' ability to implement their approved programs. The Court of Appeals paid lip service to this concern (App. at A-10, n.7), but rejected it.

suit (which it has not) or this case involves substantive rights secured either by the Fourteenth Amendment or by a federal statute expressly enacted to implement the Fourteenth Amendment (which it does not), the district court lacks jurisdiction over this action.[6]

VHA has sued the named defendants, officials of the Commonwealth, in their official capacities only. See note 1, *supra*. As a result, this action is, by consent of the parties, one that seeks relief against the Commonwealth itself, not against any officials individually. The Court of Appeals (App. at A-13) recognized that the Commonwealth is the real party at interest. Since a state, which is not a natural person, can only be required to act through its officials, there is no doubt that the relief sought by VHA -- revision of Medicaid hospital reimbursement rates --would operate only against the Commonwealth, not against the individual officials.

This Court has accepted the proposition that "[t]he Eleventh Amendment bars a suit against state officials when 'the state is the real, substantial party in interest.' " *Pennhurst, supra*, 465 U.S. at 101. Nonetheless, the ruling in this case is that, by seeking only prospective and injunctive relief, VHA has alleged a sufficient basis to bring the case under the exception to Eleventh Amendment immunity first announced by this Court in *Ex Parte Young*.

Application of *Ex Parte Young* has caused this Court increasing difficulty in recent years. *Pennhurst, supra*, 465 U.S. at 114 n.25; *Florida Dept. of State v. Treasure Salvors, Inc.*, 458 U.S. 670 (1982). The salient facts of *Young* are simple. Young, a state attorney general, continued deliberate enforcement of an allegedly unconstitutional statute in violation of a federal injunction. This Court, declining to award damages against the state, created what it now accepts to be an increasingly narrowly-construed "fiction". The "fiction" assumed that because a state would not authorize behavior such as that of Young, his actions were therefore *ultra vires* and stripped of their official character. *Pennhurst, supra*, 456 U.S. at 114 n.25. Thus, although he was acting "under color of state law" as the state's attorney general, Young was held to be acting

[6] The Medicaid Act, the sole statutory basis for this suit, is a spending power statute, as the Court of Appeals correctly assumed. App. at A-6, n.3. Congress did not evidence an "unmistakable purpose" under § 5 of the Fourteenth Amendment to abrogate the states' Eleventh Amendment immunity as a condition to receiving federal funds. *Atascadero, supra*, 473 U.S. at 247. In fact, as noted in Part A, *supra*, Congress once required a waiver of Eleventh Amendment immunity by the states in order to participate in the Medicaid Program, but specifically repealed that requirement in 1976. *Florida Dept. of Health and Rehabilitative Services v. Florida Nursing Home Assn.*, 450 U.S. 147, 150 n.3 (1981).

as an individual and not as the state, so a federal injunction would lie against him.

When applied to this case, it is clear that *Ex Parte Young* has been stretched well beyond its original facts. Its misuse in this case is evident. The practical effect of the application of the "fiction" here is to eliminate the Eleventh Amendment defense and thereby to deprive the states of their constitutional protection against federal suits.

The lower courts in this case and others have failed to analyze and apply *Ex Parte Young* correctly. The original ruling rests on two main points: (1) the conduct of Young and (2) the application of the "fiction" to allow the granting of prospective injunctive relief against a state official. But, over the years and culminating with the present case, federal courts often have looked only at the second point, the nature of the relief sought. This truncated analysis has progressed to the point where, as here, all that is necessary to defeat Eleventh Amendment immunity is for a plaintiff to allege a violation of federal law and to seek prospective relief. (App. at A-13, 14).[7]

If that is really the appropriate test, the Eleventh Amendment is rendered a mere shadow and the fictional exception developed for a "bad actor" like Young has swallowed the rule. Here, contemporaneously with the filing of this suit, the same District Court upheld the same Reimbursement System and the identical Appeals System in *Mary Washington Hospital, supra*. Both were approved by HCFA. Despite this background, officials of the Commonwealth -- named in their official capacities -- who justifiably relied upon those federal judicial and administrative approvals, have been treated by the lower courts indistinguishably from Young, a state official who defied the federal courts.

To consider the two situations analogous is neither logical nor sound policy. This Court should re-consider *Ex Parte Young* or, at the very least, should require the lower courts to engage in an examination of the facts sufficient to apply the *full* two-part analysis of that case. If that were done, it is clear that the officials of the Commonwealth sued in this case would not be shorn of their official status, and as an official-capacity suit against the Commonwealth, the suit would not be allowed to proceed in federal court. Absent application of the *Ex Parte Young* "fiction," relief that is inconsistent with the Eleventh Amendment's plain bar

[7] This Court has refused to allow plaintiffs to tailor the relief sought so as to permit an "end run" around the Eleventh Amendment. *Green v. Mansour*, 474 U.S. 64, 73 (1985). As here, VHA's suit to force revision of the Reimbursement System, while couched as a suit for prospective relief, is in reality designed to produce financial relief payable from the treasury of the Commonwealth.

against both legal and equitable remedies cannot be granted against a state.[8]

C.
The Lower Court Improperly Disregarded The Statute Of Limitations In Facial Challenges To Medicaid Regulations

The Court of Appeals ruled that a plaintiff may bring suit at any time under 42 U.S.C. § 1983 to challenge on its face a judicially and federally approved state Medicaid regulation. Under the Court of Appeals' analysis, such suit will be subject to no statute of limitations if the plaintiff merely alleges that the regulation is unconstitutional.

This stretches the "continuing violation" theory enunciated in *Brown v. Board of Education*, 347 U.S. 483 (1954) and its progeny far beyond its intended meaning.

In accordance with *Wilson v. Garcia*, 471 U.S. 261 (1985), the Court of Appeals (App. at A-15) recognized that, under 42 U.S.C. § 1983, the pertinent limitations period, borrowed from § 8.01-243(A) of the Code of Virginia, is two years. It also recognized that this case was brought in March 1986, almost four years after the promulgation of the Reimbursement System on July 1, 1982. In ruling that this action is not time-barred, the Court of Appeals ignored the critical fact that the challenged Reimbursement System had previously been upheld by the District Court.

That decision in *Mary Washington Hospital, supra*, renders illogical the Court of Appeals' conclusion that the statute of limitations has never run. The Court's analysis looks only to one aspect of the concept of a "continuing violation." The appropriate inquiry logically should involve a two-part analysis: first, whether the complained of *conduct* is continuing in nature; second, whether the allegation of a violation has any merit. Because the District Court contemporaneously with the filing of this suit had already held the challenged regulations to be facially valid (*see, Mary Washington, supra*), there is no basis in law, fact or policy to

[8] Alternatively, if this Court does sanction the routine application of the fiction that a state official may be deprived of his official status and the state of its Eleventh Amendment immunity merely through a plaintiff's pleading of federal law and request for prospective relief, these officials must of necessity be treated as sued in their individual capacities, despite the specific agreement of VHA in this case not to do so. In that event, sound policy dictates that these officials be allowed to rely upon good faith immunity as a defense, not just against damages, but from suit as well. *Mitchell v. Forsyth*, 472 U.S. 511, 526 (1985).

conclude that VHA's allegation of a violation is anything more than that -- a mere allegation. In light of these facts, application of a "continuing violation" rationale to this case is unsound. This Court should not permit a mere allegation to subject a state to relitigation of judicially approved regulations.[9]

In addition, the Court of Appeals, citing *Brown, supra, Eldridge v. Bouchard*, 645 F.Supp. 749 (W.D. Va. 1986), *aff'd* 823 F.2d 546 (4th Cir. 1987) and *Long v. Florida*, 805 F.2d 1542 (11th Cir. 1986), concluded that the "continuing violation" theory derived from these "as applied" cases should control even though the plaintiff is not a hospital to whom the challenged regulations apply. VHA, a trade association, can bring this action only as a facial challenge. It cannot allege an "as applied" violation because it is merely a surrogate for its members.[10] Nevertheless, the Court's analysis of *Brown, Eldridge* and *Long*, all cases premised upon continuing violations of civil rights' laws "as applied" to specific plaintiffs, is now the rule in the Fourth Circuit for *facial* challenges to regulations.

The practical application of this decision will lead to inconsistent and illogical results. Associational plaintiffs bringing facial challenges in federal court to state regulations will not be subject to or barred by any statute of limitations. Medicaid recipients who fail to challenge a denial or termination of their eligibility, however, will continue to be time-barred after two years, even though their ineligibility continues. Individual providers who fail to challenge a reimbursement action, even though its effect will carry forward, presumably also will continue to be time-barred. *Compare, Randall v. Lukhard*, 709 F.2d 257, 262 n.7 (4th Cir. 1983). The result is that as long as a regulation is in effect, a non-provider surrogate may now bring a facial challenge to the regulation. Such a cause of action presumably will extend indefinitely back to the date of promulgation -- in this case almost four years. This result gives associational plaintiffs greater rights than their members possess and

[9] The doctrine of *stare decisis* ought to prevent such a result, absent any changes in the facts. The lower courts, however, postponed any consideration of the application of this rule. App. at A-13, D-6. Thus, they never looked beyond the bare allegation of unconstitutionality made by VHA.

[10] *See, Virginia Hospital Association v. Baliles, supra*, 830 F.2d at 1312-1313, where the Court of Appeals found that VHA is not a health care provider and cannot be directly affected by the outcome of this litigation. Its finding is the rule of this case.

counteracts the concept of finality that is the mainstay of, and purpose behind, any statute of limitations.[11]

The decision below subjects the states to the threat of a perpetual challenge to regulations essential to the operation of their Medicaid programs. This Court can readily appreciate the potential disruption to these programs and in other areas of the law. In the interest of sound public policy, long-standing national principles of repose should not be circumvented or discarded piecemeal.

D.
Intervention By Federal Courts Into A Comprehensive State Regulatory System Violates Fundamental Principles Of Comity, Particularly When The Plaintiffs Have Not Attempted To Use That System

As a matter of comity and in the interest of orderly administration of the federal judicial system, the Court should direct federal courts not to intervene in disputes for which an adequate state remedy exists. This is particularly so where, as here, the plaintiffs have chosen to ignore a state remedy fashioned in compliance with federal law and approved both by a federal court and a federal agency.

Under this Court's decision in *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943), as further refined in *Colorado River Water Conservation District v. United States*, 424 U.S. 800 (1976), federal courts should abstain from assuming jurisdiction over a matter that is of substantial state concern. The courts especially should do so if a state has established a comprehensive regulatory framework and specialized review, if such intervention would create disruption of the state system, and if the state system can adequately vindicate any federal rights at issue.

In declining to apply the *Burford* rule, the courts below ignored the state laws and procedures constituting the Commonwealth's Medicaid Program. The Commonwealth has established an extensive system of review for the resolution of provider disputes. Title 32.1, Chapter 10 of the Code of Virginia requires DMAS and its Board to administer and

[11] Even under a true "continuing violation" theory which creates a new cause of action for every *application* of the challenged regulations, thereby renewing the applicable period of limitations, the lower courts should not have allowed this challenge to extend back in time more than two years from the 1986 filing date. If the ruling of the Court of Appeals stands, however, VHA, again as an association, may well have obtained greater rights than any of its members have individually.

regulate the payment of Medicaid funds in Virginia.[12] Section 32.1-325.1 of the Code of Virginia directs that provider appeals be administered in accordance with the State Plan and with the Virginia Administrative Process Act, § 9-6.14:1, *et seq.* of the Code of Virginia.

Acting under its statutory authority, the Board of DMAS has established the State Plan, a comprehensive regulation of several hundred pages, a significant portion of which deals expressly with provider reimbursement. The Reimbursement System defines how payments are determined for hospitals and the Appeals System provides a detailed procedure for resolution of payment disputes. Under the Appeals System, three distinct levels (informal conference, formal hearing and agency head decision) of review by administrators experienced in Medicaid reimbursement are available to every provider.

Thereafter, two levels of judicial review -- to the Virginia circuit courts and to the Virginia Court of Appeals -- are available as of right. A third, to the Supreme Court of Virginia, is available by writ. Subject to issuance of a such a writ, the Virginia Court of Appeals is vested with final appellate jurisdiction *inter alia* over decisions originating before agencies of the Commonwealth pursuant to § 17-116.07(A)(2) of the Code of Virginia. As a result, that court has developed considerable expertise in administrative law. Through its concentration in this area, it increasingly specializes in the review of administrative decisions.

The Virginia Administrative Process Act, and § 9-6.14:17 of the Code of Virginia in particular, assures that the broadest range of factual and legal issues are heard by the courts of the Commonwealth.[13] The District Court had no basis, because none exists, to suggest that Virginia courts do not provide a full and fair opportunity for resolution of disputes such as that brought by VHA. Absent a factual basis for concluding a fair hearing is unavailable in state proceedings, federal abstention is appropriate. *Ohio Civil Rights Commission v. Dayton Christian Schools*, 477 U.S. 619, 627 (1986).

Nonetheless, the courts below have ignored the Commonwealth's comprehensive review process and intervened in a state matter solely at the request of VHA. Such intervention is inconsistent with the proper operation of a federal system. Federal law mandates a state-administered system for resolution of provider disputes. The Commonwealth has a

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[12] All states participating as amici in the Court of Appeals have similar but not identical systems.

[13] *See, e.g., Bridgewater Home, Inc. v. Commonwealth of Virginia* (Va. App. Record No. 0888-87-4, July 22, 1988), a Medicaid provider dispute raising both state and federal issues.

system approved by HCFA and the District Court. Rather than allowing that system to work as intended, the Court of Appeals has sanctioned repeated federal judicial intervention into the process. Such intervention will effectively supplant the systems established by the states.[14]

It is doubly inappropriate for federal courts to intervene in the Commonwealth's Medicaid Program when, as the Court of Appeals acknowledged, none of VHA's members has attempted to prosecute any appeals filed under the Appeals System. Despite this finding, the Court of Appeals allowed VHA, on behalf of its members, to proceed with a challenge to the untested Appeals System. App. at A-16.[15]

Because no VHA member has pursued any of the appeals on file, all the lower courts had before them were assertions of aggregate hardship by a surrogate trade association. The Court of Appeals nevertheless found these allegations by VHA sufficient to meet the two requirements for ripeness -- appropriateness for judicial resolution and hardship -- announced by this Court in *Toilet Goods Association, Inc. v. Gardner*, 387 U.S. 158, 162 (1967). This Court should require the lower courts to decline to entertain speculative actions in which no state record has been developed, particularly in the context of a state Medicaid program. *See, e.g., Wilmac Corporation v. Bowen*, 811 F.2d 809 (3rd Cir. 1987).

This Court should direct the lower courts to abstain from entertaining this action in the absence of any compelling reason to do so and in the absence of a justiciable dispute. If it does not, similar appeals are likely to burden the federal court system and disrupt the states' administration of their various Medicaid programs.

VII.
CONCLUSION

The lower courts have improperly restructured the national Medicaid Program and have eliminated Eleventh Amendment immunity, as well as the application of any statute of limitations, in an action such as

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[14] The Medicaid Act and federal regulations require uniform statewide application of the State Plan. *See, e.g.*, 42 C.F.R. § 431.50. Moreover, it is axiomatic that administration of the Virginia Medicaid Program, which exceeds eight percent of the Commonwealth's total biennial budget, is a matter of substantial concern to the Commonwealth.

[15] In successfully asserting its standing to bring this suit, VHA convinced the courts below it does not need to use data specific to its individual member hospitals. (App. at A-14, 15; D-4). Accordingly, the outcome of this facial challenge cannot resolve the specific reimbursement disputes of any of those hospitals. Because none has pursued an appeal, none actually knows whether it can obtain increased reimbursement under present procedures. Success in this litigation will not change that result.

this. Federal court intervention threatens principles of comity and the orderly administration of state Medicaid programs. For these reasons, the Court of Appeals' ruling should be reversed.

WHEREFORE, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOCIATION

Plaintiff-Appellee

versus

GERALD BALILES, Governor of Virginia; EVA S. TEIG, Secretary of Human Resources of Commonwealth of Virginia; BRUCE U. KOZLOWSKI, Director, Medical Assistance Services; BETTE O. KANTER, Member State Board of Medical Assistance Services; JOSEPH M. TEEFY, Member State Board of Medical Assistance Services; R. MICHAEL BERRYMAN, Member State Board of Medical Assistance Services; FORD TUCKER JOHNSON, SR., D. D. S. Member State Board of Medical Assistance Services; A. EPPS, JR., Medical Doctor; RUTH HANFT, Member State Board of Medical Assistance Services; BERTHA L. DAVIS, Ph.D., Member State Board of Medical Assistance Services; KATHLEEN LEUTZE, Member State Board of Medical Assistance Services; ROBERT N. LAMBETH, JR., Member State Board of Medical Assistance Services; ELSA A. PORTER, Member State Board of Medical Assistance Services; JOHN N. SIMPSON, Member State Board of Medical Assistance Services;

Defendants-Appellants

State of Alaska; State of Arizona; State of California; State of Florida; State of Georgia; State of Idaho; State of Indiana; State of Kansas; State of Michigan; State of Minnesota; State of Missouri; State of New Hampshire; State of New Jersey;

State of New Mexico; State of North Dakota; Commonwealth of Pennsylvania; State of Rhode Island; State of South Carolina; State of South Dakota; State of Tennessee; State of Vermont; State of Wisconsin; State of Wyoming; American Hospital Association

Amicus Curiae

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Robert R. Merhige, Jr., Senior District Judge. (CA 86-166-R)

Argued: October 31, 1988 Decided: February 22, 1989

Before RUSSELL and ERVIN, Circuit Judges, and KISER, United States District Judge for the Western District of Virginia, sitting by designation.

Roger Lewis Chaffe, Senior Assistant Attorney General (Mary Sue Terry, Attorney General; R. Claire Guthrie, Deputy Attorney General; Pamela M. Reed, Virginia R. Manhard, Assistant Attorneys General, on brief) for Appellants. Martin Andrew Donlan, Jr. (Judith B. Henry, Peter M. Mellette, Lynne Fleming, CREWS & HANCOCK on brief) for Appellee. (Gregory M. Luce, Irwin Cohen, Martha Ellett, Eric Schwartz, FULBRIGHT & JAWORSKI; Michael F. Anthony, AMERICAN HOSPITAL ASSOCIATION on brief) for Amicus Curiae American Hospital Association. (Dave Frahnmayer, Attorney General of Oregon, William F. Gary, Deputy Attorney General, Virginia L. Linder, Solicitor General, Kendall M. Barnes, Jr., Assistant Attorney General; Grace Berg Schaible, Attorney General of Alaska; Robert K. Corbin, Attorney General of Arizona; John K. Vandekamp, Attorney General of California; Robert A. Butterworth, Attorney General of Florida; Michael J. Bower, Attorney General of Georgia; James T. Jones, Attorney General of Idaho; Linley E. Pearson, Attorney General of Indiana; Robert T. Stephan, Attorney General of Kansas; Frank J. Kelley, Attorney General of Michigan; Hubert H. Humphrey, III, Attorney General of Minnesota; William L. Webster, Attorney General, State of Missouri; Brian McKay, Attorney General of Nevada; Stephen E. Merrill, Attorney General of New Hampshire; Cary Edwards, Attorney General of New Jersey; Hal Stratton, Attorney General of New Mexico; Nicholas Spaeth, Attorney General of North Dakota; Leroy S. Zimmerman, Attorney General, John G. Knorr, III, Chief Deputy Attorney General, Commonwealth of Pennsylvania; James E. O'Neil, Attorney General of Rhode Island; T. Travis Medlock, Attorney General of Sourth Carolina; Roger A. Tellinghuisen, Attorney General of South Dakota; W. J. Michael Cody, Attorney General of Tennessee; Jeffrey L. Amestoy, Attorney General of Vermont; Donald J. Hanaway, Attorney General of Wisconsin; Joseph B. Meyer, Attorney General of Wyoming, on brief) for state Amici Curiae.

ERVIN, Circuit Judge:

Defendants, officials of the government of the Commonwealth of Virginia,[1] (hereinafter collectively referred to as "Virginia") appeal the denial of their motion for summary judgment seeking to dismiss an action commenced against them by the Virginia Hospital Association ("VHA"). VHA is a nonprofit organization, the members of which are all public or private Virginia health care providers, principally hospitals ("providers"). VHA sued to enjoin the procedures Virginia uses to determine what rate of reimbursement VHA members receive for treating Medicaid patients. Virginia argued that for various reasons VHA's suit is not currently justiciable. The district court disagreed and certified its order for appeal under 28 U.S.C.A. § 1292(b). We affirm.

I

VHA brought this § 1983 action to challenge Virginia's procedures for reimbursing hospitals for the costs of treating Medicaid patients ("Virginia Plan").[2] VHA seeks the following relief: (1) a declaration that the Virginia Plan violates the Medicaid Act, 42 U.S.C.A. § 1396 *et seq.* ("Medicaid Act"), and therefore also the Supremacy Clause ("Count I"); (2) a declaration that the Virginia Plan violates its members' due process rights ("Count II"); (3) a permanent injunction of the Virginia Plan ("Count III").

On September 22, 1986, the district court granted summary judgment for Virginia on the ground that collateral estoppel precluded VHA from litigating issues decided in *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), a similar action brought by one VHA member hospital. We reversed that decision and remanded the case. *Virginia Hospital Association v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

Virginia then moved for summary judgment based on a number of nonjusticiability arguments. Virginia disputed VHA's contention that the Medicaid Act creates a right actionable under § 1983, and argued that the Medicaid Act evidences a congressional intent to foreclose private enforcement. Virginia further contended that *stare decisis* or the Eleventh Amendment barred VHA's suit, and that VHA lacked standing. Virginia alleged finally that the statute of limitations barred VHA's claim, that the claim is not ripe, and that the district court should abstain.

The district court denied Virginia's motion, holding the action currently justiciable. We agree and affirm.

II.

We believe Virginia's most substantial argument is that VHA has no right actionable under § 1983, and so we address that issue first.

A.

Virginia argues that only health care recipients, and not individual or associated health care providers, have rights enforceable under the Medicaid Act. We agree with the district court that the Medicaid Act supplies VHA with an enforceable right, and that Virginia failed to establish a congressional intent to foreclose private enforcement.

Section 1983 supplies VHA with no substantive rights. The statute serves simply as a vehicle to redress the deprivation under color of state law "of any rights . . . secured by the [federal] Constitution and laws. . . ." 42 U.S.C.A. § 1983 (West 1981). The initial query is accordingly whether the Medicaid Act provides VHA with any substantive right.

There is no dispute that the Medicaid Act does not expressly confer a right of action on health care providers. The Supreme Court has held, however, that federal statutes may imply rights actionable under § 1983. *Maine v. Thiboutot*, 448 U.S. 1 (1980). A number of cases decided since *Thiboutot* have elaborated criteria for determining whether a particular statute implies a private right of action. In *Pennhurst State School v. Haldeman*, 451 U.S. 1, 15 (1981), the Court made plain that the touchstone of the determination is congressional intent, as manifest in the language and legislative history of the statute. *See also Middlesex City Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 13 (1981).

In *Pennhurst*, the Court examined the text and legislative history of the Developmentally Disabled Assistance and Bill of Rights Act of 1975

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[1] Defendants are the Governor of the Commonwealth of Virginia, Gerald L. Baliles, as well as the Commonwealth's Secretary of Human Resources and Director of Medical Assistance Services, and members of the Commonwealth's Board of Medical Assistance Services ("DMAS").

[2] The Omnibus Budget Reconciliation Act of 1981 ("OBRA") included the Boren Amendment, codified at 42 U.S.C.A. 1396a(a)(13)(A) (West Supp. 1988). The Boren Amendment requires Virginia, as a participant in the Medicaid program, to "provide . . . for payment . . . of the [medical] services provided under the [Virginia Plan] through the use of rates . . . which [Virginia] finds, and makes assurances satisfactory to the Secretary [of Health and Human Services], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable . . . laws. . . ." Section 1396a(a)(13)(A) amended § 1396a(a)(13)(E), under which Virginia *had* been required to determine reimbursement rates "on a reasonable cost-related basis. . . ." In 1982, Virginia amended its Medicaid Plan to incorporate a prospective reimbursement rate-setting mechanism.

("Assistance Act"), 42 U.S.C.A. § 6000 *et seq.*, a statute similar in some respects to the Medicaid Act. Both statutes create programs whereby the Federal Government provides money to States to fund programs for persons specially in need. State participation is voluntary under both statutes, but both require participating states to meet certain conditions to receive federal funds.[3]

The Court in *Pennhurst* noted that while many provisions of the Assistance Act expressly conditioned federal assistance on state compliance, the provision at issue, 42 U.S.C.A. § 6010, did not. 451 U.S. at 13. The Court also noted that the right the mentally retarded respondents claimed, that of "appropriate treatment" in the "least restrictive environment", would impose a massive financial obligation on participating states. 451 U.S. at 16-17. After examining the language and legislative history of § 6010 and other sections of the Assistance Act, the Court concluded that § 6010 was merely precatory and did not create a right in favor of the respondents. *Id.* at 18. *See Wright v. Roanoke Redev't & Hous. Auth.*, 479 U.S. 418, 423 (1987) ("In *Pennhurst*, a § 1983 action did not lie because the statutory provisions were thought to be only statements of "findings" indicating no more than a congressional preference — at most a "nudge in the preferred directio[n]," 451 U.S. at 19, and not intended to rise to the level of an enforceable right.").

We note at the outset of our analysis that two other circuits appear to have concluded that § 1396a(a) (13) (A) supplies providers with enforceable rights. *Colorado Health Care Ass'n v. Colorado Dep't of Social Serv.*, 842 F.2d 1158, 1164 n.5 (10th Cir. 1988); *Coos Bay Care Ctr. v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), *cert. granted*, 107 S. Ct. 2970, *vacated as moot*, 108 S. Ct. 52 (1987). Because VHA is, for purposes of this decision, simply a medium through which its members have elected to litigate, these decisions respecting individual providers pertain to our consideration of VHA's derivative rights. We are also aware that another district court in this circuit appears to have reached the opposite conclusion in a case

[3] The parties to this case have not briefed or argued under what constitutional provision Congress enacted the Medicaid Act. In *Pennhurst*, the Court found little support for the position that Congress had enacted the Assistance Act pursuant to its power under § 5 of the Fourteenth Amendment. 451 U.S. at 18. The Court instead concluded that Congress had acted pursuant to its spending power under Art. I, § 8, Cl. 1. For statutes enacted under the spending power, the Court held that "if Congress intend[ed] to impose a condition on the grant of federal monies, it must [have done] so unambiguously" and subject to certain limits not relevant to the decision. *Id.* at 17 and n.13. We assume that the Medicaid Act reflects the exercise only of Congress' spending power, and therefore conclude that the holdings in *Pennhurst* are among those that control in this case.

pending before us. *Vantage Healthcare Corp. v. Department of Medical Assistancse Services*, 684 F. Supp. 1329 (E.D. Va. 1988) (appeal pending as No. 88-3872). The substantive issue in *Vantage* is not, as here, the propriety of reimbursement rates generally, but whether providers are entitled to a certain type of reimbursement, called a return on equity capital. This distinction means our decision in this case does not foreordain the outcome of *Vantage* and, as a corollary, that the district court's dismissal of Vantage's § 1983 action does not necessarily bear on our resolution of this appeal.

We believe the language and legislative history of § 1396a(a) (13) (A) imply a congressional intent to allow providers a right of action against State failure to comply with federal Medicaid requirements. Virginia proposes, though, that the significant language of § 1396a(a)(13)(A) is the clause requiring Virginia to assure the Secretary of its compliance. In Virginia's view, as we understand it, it is the elaborate statement of the section's public welfare goals, [stipulating the conditions with which Virginia must comply] that is precatory. Once the Secretary has accepted Virginia's assurances that the plan will comply, there is no federal judicial authority to consider whether Virginia has made good on its promise. We believe a reading of § 1396a(a)(13)(A) in the context of the Medicaid Act, as *Pennhurst* requires, alone refutes Virginia's interpretation. The comments of the Congress that enacted the Boren Admendment dispel the argument even more forcefully.

It is true that § 1396a(a)(13)(A) does not in so many words condition federal assistance on state compliance with its express purpose, which is to require reimbursement rates that are "reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated [providers] . . . and to assure that [Medicaid patients] have reasonable access . . . to inpatient hospital services of adequate quality. . . ." Virginia proposes that the intent behind § 1396a(a)(13)(A) is not forcefully to effect this purpose, but, as with the provision at issue in *Pennhurst*, simply to "nudge" the states toward action Congress did not see fit to make mandatory. We cannot agree with the proposition and conclude that § 1396a(a)(13)(A) reveals an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact.

Even a cursory reading of the forty-nine provisions of 42 U.S.C.A. § 1396a(a), which stipulate what a state Medicaid plan must include and provide, reveals that none is expressly conditional. Each provision is rather subject to the imperative of their predicate § 1396a(a), which indicates that the provisions specify what a State plan "must" contain. We believe the district court correctly concluded that § 1396a(a)(13)(A) reveals a

congressional intent to condition federal assistance on states' achievement of the express purpose of the section, and not simply on states' assurances of compliance.[4]

B.

The legislative history of § 1396a(a)(13)(A) strongly reinforces our interpretation. The Joint Explanatory Statement of the Committee of Conference, commenting on the bill as enacted, states flatly that "the conferees intend that state hospital reimbursement policies should meet the costs that must be incurred by efficiently administered hospitals in providing covered care and services to medicaid eligibles. . . ." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess.*reprinted in* 1981 U.S. Code Cong. & Admin. News 1324. The Conference Committee's bill contained much of the text of the bill proposed by the Senate Finance Committee, which had included "a provision requiring states to reimburse hospitals at rates (determined in accordance with methods and standards developed by the states) that are reasonable and adequate to meet the cost [sic] which must be incurred by efficient . . . and economical . . . [providers]." S. Rep. No. 139, 97th Cong., 2d Sess., *reprinted in* 1981 U.S. Code Cong. & Admin. News 697. The Committee's comments make plain that the latitude § 1396a(a)(13)(A) grants States is not willfully to assign reimbursement rates, but flexibly to determine what methods and factors will produce rates adequate in fact given the circumstances particular to each State's hospitals.[5]

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[4] The regulations implementing § 1396a(a)(13)(A) reinforce our interpretation that the section's requirement of adequate state assurances evinces no congressional intent to insulate State Medicaid reimbursement systems from federal judicial scrutiny. 42 C.F.R. §§ 447.250-280 (1987). The regulations suggest that the Secretary's task is not to consider the reasonableness of reimbursement rates at large, but rather to consider the adequacy of state assurances that "the methods and standards used by the [State] to set payment rates [are] consistent with 45 C.F.R. 201.2." 42 C.F.R. § 447.252(b); see also 42 U.C.C.A. § 1396a(a)(13)(A) (stating parenthetically that the states are responsible for developing methods and standards for determining reimbursement rates), 42 C.F.R. § 447.253(a)-(b). Moreover, the Secretary need not examine state assurances at all; 42 C.F.R. § 447.256(b) states that a state's assurances will be deemed accepted by the Secretary if the Secretary fails to notify the State of its determination within 90 days of receipt of the assurances.

[5] *Cf.* S. Rep. No. 139, 97th Cong., 2d Sess., *reprinted in* 1981 U.S. Code Cong. & Admin. News 744 (Summary of Finance Committee Recommendations) ("The bill provides States with additional flexibility in determining the payment rate for inpatient hospital services. . . . [The bill] substitutes a provision requiring states to reimburse hospitals at rates

(Continued on next page.)

The legislative history also indicates that Congress intended no close scrutiny by the Secretary of Virginia's assurances of compliance with the mandates of § 1396a(a)(13)(A). 1984 U.S. Code Cong. & Admin. News 744. ("The [Senate Finance] committee expects that the Secretary will keep regulatory and other requirements to the minimum necessary to assure proper accountability, and not to overburden the states and [providers] with unnecessary and burdensome paperwork requirements. It is expected that the assurance made by the states will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.") See supra p. 9 n.3. This history indicates further the unreason of Virginia's proposition that Congress intended state review and assurances to be the sole means of assuring that the Virginia system provides reasonable access to care of adequate quality.

We are aware that OBRA purposed to reduce the federal budget, that § 1396a(a)(13)(A) aims to promote this purpose by implementing a more cost-efficient Medicaid scheme, and that a logical reading of § 1396a(a)(13)(A) could accordingly be that it insulates State reimbursement programs from challenges by hospitals compensated at new, lower rates. Our reading of § 1396a(a)(13)(A), however, is that it guarantees reasonable and adequate reimbursement to hospitals that achieve cost-efficiency. We believe that only this reading protects the balance for which Congress has striven between insuring health care to the poorest citizens and imposing a manageable burden on the federal and state treasuries.

Our view of § 1396a(a)(13)(A) allays the concern understandably influential in *Pennhurst*, that implying a private right of action may lead to crushing financial burdens that participating states could not have foreseen when they elected to participate in the Medicaid

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[5] *(Continued from previous page.)* (determined in accordance with methods and standards developed by the States) that are reasonable and adequate to meet the cost [sic] which must be incurred by efficiently and economically operated [providers] . . . The Committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs . . . The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care.") The comments make plain that while States have considerable freedom to structure their reimbursement programs to encourage and maintain efficiency, the programs must produce rates related to providers' reasonable costs. These goals are not inconsistent. For example, the Committee comment indicates that a State could categorize providers in any number of ways. *Id.* As long as the categorization allowed for the promulgation of reasonable reimbursement rates, providers' complaints that another system would produce preferable rates would be unavailing.

program.[6] 451 U.S. at 24-25. Virginia has not argued that the obligation VHA seeks to enforce against it, that it provide reasonable and adequate reimbursement rates, does not exist, or that Virginia could not reasonably have foreseen that we could interpret § 1396a(a)(13)(A) as we do today. Virginia argues only that a § 1983 action was not a permissible route by which VHA could present the merits of its grievance. We do not take any position on the merits of that grievance, but agree with the district court's threshold determination that VHA has a right enforceable under § 1983.

C.

Having concluded that § 1396a(a)(13)(A) confers a right on providers, we must now consider whether the Medicaid Act's enforcement provisions reveal an intent to foreclose a private judicial remedy for abridgement of the right. We observe at the outset that exhaustion of state administrative remedies is not ordinarily a prerequisite to commencing a § 1983 action. *Patsy v. Board of Regents*, 457 U.S. 496, 507-12 (1986). *Patsy* does not, however, displace the holding of *National Sea Clammers*, 453 U.S. at 13-14, that the constellation of enforcement mechanisms, administrative and otherwise, available under a federal statute may be so elaborate as to evince a congressional intent to bar additional judicial remedies. We believe that the enforcement mechanisms under the Medicaid Act evince no such intent, and hold that VHA is not foreclosed from seeking redress through a § 1983 proceeding.[7]

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[6] The court in *Pennhurst* "assume[d] that Congress will not implicitly attempt to impose financial obligations on the state." 451 U.S. at 17. It seems equally reasonable for us to assume that Congress would not, as it has in the Hill-Burton Act, 42 U.S.C.A. § 291 *et seq.* require many VHA members to participate in the Virginia Plan but implicitly deny the members an enforceable right to reimbursement rates that meet their costs.

[7] We recognize amici's concerns that authorizing § 1983 actions to redress grievances against State reimbursement systems subverts Congressional intent to give State administrators sole jurisdiction over such grievances and invites a multiplicity of suits burdensome both to State Attorneys General and to the federal courts. We have dealt at length, and shall do so further, with the first concern. As to the second, we note that while the Supreme Court in *Pennhurst* indicated that the foreseeability and financial consequences to the States of recognizing an implied right of action may properly influence our decision, 451 U.S. at 24-25, we have not found authority instructing us to account for the threat of burdensome litigation when analyzing a claim of an implied right of action. To the extent this appeal sheds light on that concern, though, we believe it assuages it. We indicate below that *stare decisis* may foreclose litigation of issues in this case, and can foresee that *stare decisis* or res judicata resulting from this challenge to Virginia's system may obtain in future similar actions brought by VHA or its members. Also, of course, the Virginia providers' election to claim through VHA seems to allay, rather than heighten, the concern that this action augurs numerous suits by single or small groups of providers.

The burden is on Virginia to "demonstrate . . . by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright v. City of Roanoke Redev't and Hous. Auth.*, 479 U.S. 418, 423 (1987); see also *Smith v. Robinson*, 468 U.S. 992, 1011-12 (1984), *National Sea Clammers*, 453 U.S. at 13. Congress has not expressly foreclosed private enforcement of the Act. We agree with the district court that Virginia has not satisfied its burden of showing an implied intent to foreclose private judicial enforcement.

The Act lacks any provision for a judicial remedy. The Supreme Court has found such a lack a strong indicium of an intent not to foreclose. *Wright*, 479 U.S. at 427; *Smith*, 468 U.S. at 1011; *National Sea Clammers*, 453 U.S. at 14-17.

The Secretary, through the Health Care Financing Administration ("HCFA"), possesses some authority to review State plans. As we have noted, § 1396a(a)(13)(A) requires State assurances "satisfactory to the Secretary." 42 U.S.C.A. § 1396a(a)(42) empowers the Secretary to audit state plans as necessary to insure proper reimbursement. 42 U.S.C.A. § 1396c allows the Secretary to withdraw federal funds from states found not in compliance.

In *Wright*, however, the court found federal agency "authority to audit, enforce . . . contracts, and cut off federal funds . . . [to be] generalized powers . . . insufficient to indicate a congressional intention to foreclose § 1983 remedies." 479 U.S. at 428.[8] Also similar to the facts of *Wright* is the apparent absence of any formal mechanism by which providers may bring complaints about state Medicaid administration to the Secretary's attention. *Id.*

The Medicaid Act is not, however, the exclusive source of oversight mechanism. Virginia has established an administrative appeals mechanism whereby VHA and its members may air at least some of their

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[8] We assume, as Virginia argues, that HCFA has vigorously exercised its enforcement power. We also agree with Virginia that in *Phelps v. Housing Auth. of Woodruff*, 742 F. 2d 816, 821 (4th Cir. 1984), we gave substantial weight to a federal agency's vigorous exercise of its audit power and to its authority to withhold funds in concluding that a statute foreclosed private enforcement. We believe that *Wright*, decided after *Phelps*, requires us to give less weight to the Act's oversight provisions and the Secretary's vigor in assessing whether Virginia has met its burden than *Phelps* gave to HUD's authority.

grievances.[9] The Supreme Court has instructed us, though, that "the existence of a state administrative remedy does not ordinarily foreclose resort to § 1983." *Wright*, 479 U.S. at 427-28 (citing *Patsy*, 457 U.S. at 516). Nor does *Wright* suggest that we should somehow amalgamate federal and state remedial mechanisms in considering foreclosure. *See also National Sea Clammers* 453 U.S. at 17 (focusing on remedies "expressly provided by Congress."). Even if amalgamation were correct, we do not believe the mechanisms together amount to a congressionally-directed remedial scheme so comprehensive as to forclose a private judicial remedy.

III.

We next consider whether the district court was correct to refuse Virginia's request for summary judgment based on *stare decisis*. Virginia contends that the district court's decision in *Mary Washington Hospital Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), an action brought by a single VHA member hospital against various DMAS officials, has addressed all of the allegations raised here by VHA.[10] The district court declined to conclude that *stare decisis* warranted dismissal at this stage, but recognized that *stare decisis* may well apply to issues as they crystallize through further proceedings. We affirm, based on our conclusion that the reimbursement system has changed since the decision in *Mary Washington*, but emphasize our approval of the district court's willingness to revisit the issue as seems appropriate.

The district court in *Mary Washington* described the case as a challenge by a provider of "the failure of Virginia's [reimbursement] system to take into account [the hospital's location] and other factors

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[9] Virginia promulgated its appeals mechanism not in response to the Medicaid Act itself, but to a regulation promulgated thereunder by the HCFA. The regulation states, "The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative reviews, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(c).

Notably, the regulation appears not to authorize appeals by class representatives such as VHA. The regulation also leaves to State discretion what issues to entertain. Counsel for VHA stated at oral argument what we understand Virginia not to have disputed, that the Virginia Plan's appeals system would refuse to consider certain of the allegations raised in VHA's complaint.

[10] Because the parties had not then presented the issue, we expressly refrained from considering the *stare decisis* implications of *Mary Washington* in our earlier visit to this case. *Baliles*, 830 F.2d at 1311 n.3.

that allegedly affected its costs of efficient operation." 635 F. Supp. at 896. The provider had also challenged "the use of the [consumer price index] as the reimbursement escalator and particularly the failure of the system to recognize increases in operating costs resulting from the addition of new and necessary services." *Id.* The court also observed "that the potential future inadequacy of Virginia's rates under the current system is not now a properly justiciable issue". *Id.* at 901. It is, of course, precisely this issue that VHA seeks to litigate in this action.

The decision in *Mary Washington* was sufficiently fact specific, and the holdings there sufficiently distinct from what would have been dispositive here, that there were not clear bases on which to dismiss VHA's action outright. It is true that *Mary Washington* upheld all aspects of the Virginia plan save its appeals mechanism. Virginia has since promulgated a new appeals mechanism, and now employs a different reimbursement escalator. It was not error for the district court to identify differences between *Mary Washington* and this case sufficient to justify allowing VHA to proceed further.

IV.

We now address the remainder of the arguments Virginia has presented in favor of nonjusticability.

A.

The correct analysis of Virginia's contention that the Eleventh Amendment bars VHA's suit is set forth in *Ex parte Young*, 52 L.Ed. 714 (1908), and its progeny. *Ex parte Young* recognized an exception to the States' Eleventh Amendment immunity for suits that charge state officials with violations of federal law and request prospective relief. We note first that VHA has requested no retroactive monetary relief, and has named as defendants not the Commonwealth itself or any of its agencies or departments, but only certain Commonwealth officials. *See Papasan v. Allain*, 92 L.Ed.2d 209, 226-27 (1986).

Virginia nonetheless asserts that the Commonwealth is the "real party in interest" to the action and that VHA seeks disguised monetary relief in the form of higher reimbursement rates. Virginia is, of course, correct to some extent, but has nonetheless failed to identify why the case is not within the *Ex parte Young* exception. A suit against Virginia officials for actions done in obedience to Commonwealth law naturally interests the Commonwealth, but is just the sort of action *Ex parte Young* authorized. The Supreme Court has also repeatedly recognized

that "relief that serves directly to bring an end to a present violation of federal law is not barred by the Eleventh Amendment even though accompanied by a substantial ancillary effect on the state treasury." *Papasan*, 92 L.Ed.2d at 227; *see also Milliken v. Bradley*, 53 L.Ed.2d 745 (1977); *Edelman v. Jordan*, 39 L.Ed.2d 662 (1974). We believe the district court correctly held this action not barred by the Eleventh Amendment.

B.

VHA claims associational standing in behalf of its member hospitals. The standard is whether: (1) the members otherwise have standing; (2) the interest VHA seeks to promote is germane to its purpose;[11] and (3) neither the claims asserted nor the relief requested require the participation of member hospitals. *Coles v. Havens Realty Corp.* 633 F.2d 384, 390 (4th Cir. 1980) (citations omitted) *aff'd in part, rev'd on other grounds sub nom. Coleman v. Havens Realty Corp.*, 455 U.S. 363 (1982). The district court found Virginia to have disputed only the third *Coles* criterion, and concluded that VHA was challenging conduct affecting its members generally and that VHA's claim for equitable relief was less likely to require members' participation than would a damages action. The court indicated, however, that it would be willing to reconsider if evidence surfaced that lent further support to Virginia's characterization.

Virginia here argues that the district court incorrectly assessed the evidence on the third *Coles* criterion. Virginia also contends that VHA had no direct or proprietary interest in the adequacy of Medicaid rates and so has no interest sufficient to create a case or controversy with Virginia. *Cf. Baliles*, 830 F.2d at 1315 (Phillips, J., dissenting) ("The standing issue is critically related to the collateral estoppel issue in ways that might well force VHA into somewhat conflicting positions on the nature and degree of the associational relationships here at issue.") We believe, given the district court's resolution of the first two *Coles* criterion and Virginia's failure to submit new evidence on either, that there is little substance to the case or controversy argument. While there may be some inconsistency between allowing VHA to excape the collateral estoppel effects of one of its member's litigation and recognizing VHA's ability to litigate in its members' behalf, we believe VHA satisfies the *Coles* criterion.

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[11] According to its complaint, VHA's purpose is "developing and improving the hospital industry in Virginia."

Virginia argues that the district court will have to examine data and make findings for each VHA member hospital in order to resolve VHA's claims and, if appropriate, to grant the requested relief. If this were right, or if it appeared to be so at this stage, Virginia might be correct that VHA fails to satisfy the third *Coles* criterion. We think though, that Virginia's argument is not now valid.

As the district court observed, VHA "asserts it is challenging factors common to all of the hospitals." VHA's claims are against the Virginia Plan, and it has requested relief that would result in the reform of the plan. While reform certainly affects each member hospital, and may at some point require proceedings directed toward sets of providers smaller than VHA, VHA has not requested that the district court do anything but consider the plan. Virginia has not made clear why the district court must necessarily inquire into the affairs of each provider or of smaller groups of providers to do what VHA requests, and we find no evidence in the pleadings or elsewhere that suggests trial or an order in favor of VHA would require findings specific to its individual members. We therefore believe the district court was correct to recognize VHA's standing at this stage, although we endorse the court's willingness to revisit this issue if further progress reveals evidence that VHA should not have standing to proceed alone.

C.

The parties agree that the pertinent limitations period is two years. They also agree that VHA's cause of action first arose on July 1, 1982, when Virginia enacted its current reimbursement plan. VHA filed its complaint on March 19, 1986. The district court found that VHA had alleged an ongoing constitutional violation, and that the statute would not have begun to run untill the violation ended. We believe this was correct.

Virginia argues that the district court's decision would nullify all statutes of limitation with respect to statutory challenges. The district court, however, held only that "[t]he continued enforcement of an unconstitutional statute cannot be insulated by the statute of limitations", a holding in line with appellate precedent. *Brown v Board of Education*, 347 U.S. 483 (1954); *Eldridge v. Bouchard*, 645 F. Supp. 749 (W.D. Va. 1986), *aff'd* 823 F.2d 546 (4th Cir. 1987); *Long v. Florida*, 805 F.2d 1542, (11th Cir. 1986), *cert. denied*, 108 S. Ct. 78 (1987).

Virginia's subsdiary argument, that the statute of limitations should bar VHA from suing based on conduct after March 19, 1984, seems to

repeat its principal argument, and to fail for the same reason. Virginia recognizes that a partial bar would preclude a challenge to the entire reimbursement system and limit the issues to the validity of relatively minor or as-yet-unimplemented aspects of the system. This is patently incompatible with the district court's holding that the limitations period cannot protect an allegedly unconstitutional program.

D.

The district court determined that VHA's claims were ripe as essentially legal products of final agency action and because of the hardship delay would produce.[12] *Abbott Laboratories v. Gardner*, 387 U.S. 136, 169 (1967). The Court found the Virginia plan to have operated for several years, making its enforcement not a matter of speculation. VHA's claim of deficient reimbursement rates presents a purely legal issue. Because VHA challenged the system and not individual providers' reimbursement rates, the court found inapposite Virginia's contention that providers should first have to appeal through the plan's administrative apparatus.

Toilet Goods Ass'n v. Gardner, 387 U.S. 258 (1967), on which Virginia relies heavily, supports the district court's decision. In *Toilet Goods*, a group of cosmetics manufacturers challenged an FDA regulation allowing unannounced inspections of the manufacturers' plants. The FDA had not yet applied its regulation, and the Court found its effect therefore speculative. 387 U.S. at 164. In this case, VHA has levied a challenge to a system that has operated for some years and the products of which, the reimbursement rates, VHA believes inadequate. Although no VHA member hospital has prosecuted its case through the administrative appeal mechanism, this mechanism is also the subject of VHA's challenge. VHA has framed its suit as a denial of the legitimacy of the entire Virginia plan. We think the district court was correct to hold that the effects of this system are now sufficiently clear to defeat an argument that VHA's suit is premature.

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[12] In *Randall v. Lukhard*, 709 F. 2d 257 (4th Cir. 1983), *relevant holdings adopted on rehearing en banc*, 729 F.2d 966 (4th Cir.), *cert. denied*, 469 U.S. 872 (1984), we held that for statute of limitations purposes the date on which the plaintiffs' cause of action arose was that of the "final unfavorable administrative action" revoking eligibility for Medicaid. 709 F.2d at 262 n.7. In *Randall*, we considered whether the Commonwealth of Virginia had properly denied Medicaid benefits to a number of individual claimants. The discrimination action in *Randall* was a matter of history and not as in this case, a practice that continues as a matter of settled state policy and that affects plaintiffs still involved in the Medicaid system. We therefore perceive no incompatibility between *Randall* and our resolutions of the statute of limitations and ripeness issues in this case.

Toilet Goods also supports VHA's position on hardship. In *Toilet Goods*, the Court found the burdens of preliminary compliance and of piecemeal administrative challenges a sufficient hardship to satisfy a ripeness test. 387 U.S. at 173-74. Here, VHA alleges that its members' reimbursement rates and opportunity for redress through the administrative apparatus are inadequate. Delay would increase the costs to VHA members, costs the Eleventh Amendment will likely bar them from recovering through a federal suit. VHA members are, moreover, legally obliged to treat Medicaid patients no matter the members' reimbursement rates. For these reasons, we think VHA has shown sufficient hardship to satisfy the *Abbott Laboratories* test.

E.

Virginia believes the district court should have abstained under either *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943) or *Railroad Comm'n of Texas v. Pullman Co.*, 312 U.S. 496 (1941). The district court gave brief attention to the *Pullman* doctrine, finding little to indicate that it applied. We believe this was correct. *Pullman* abstention is appropriate in a case that involves unsettled issues of state law, the erroneous resolution of which by the federal court would trouble all concerned. This case does not appear to present any unsettled issues of Commonwealth law save, perhaps, the necessity of appealing administratively before suing in federal court. As we have written earlier, we think there is no such necessity here.

In *Burford*, the Court held that it was proper for a federal court to abstain from deciding a challenge to an oil field proration order issued by a Texas regulatory commission. The Court reasoned that the proper allocation of oil resources was a matter of substantial state concern, for which the state had set up a comprehensive regulatory scheme; that there was a significant need for uniform decision-making in the area, which the state had attempted to provide by consolidating review of all claims involving oil allocation in specialized state courts; that the intervention of the lower federal courts would create precisely the sort of disuniformity that the state system was designed to avoid; and that the state courts could adequately vindicate the federal rights at issue. 319 U.S. at 327-34. Under such circumstances, the Court held, fundamental principles of comity require the federal courts to stay their hand.

The district court found that the Virginia plan was not the sort of comprehensive regulatory system it was bound to respect through abstention. The court also found that VHA could not have prosecuted its

federal claims through the administrative appeals apparatus, and that the Medicaid Act revealed Medicaid to be the subject of both state and federal concern. *Curtis v. Taylor*, 648 F.2d 946, 949 (5th Cir. 1980). In short, the district court found little that dovetailed with the *Burford* rationale for abstention. We think this was fairly plainly correct.

V.

For the reasons stated above, the district court's order denying Virginia's motion for summary judgment is affirmed.

AFFIRMED.

FILED
Mar. 22, 1989
U.S. Court of Appeals
Fourth Circuit

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOCIATION

Plaintiff-Appellee,

v.

GERALD BALILES, etc., et al,

Defendants-Appellants.

On Petition for Rehearing with Suggestion for Rehearing In Banc

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The appellants' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied.

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

Entered at the direction of Chief Judge Ervin, with the concurrence of Judge Russell and Judge Kiser, United States District Judge sitting by designation.

For the Court

JOHN M. GREACEN
CLERK

FILED
Mar. 29, 1989
U.S. Court of Appeals
Fourth Circuit

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOC.,

Plaintiff-Appellee,

v.

GERALD BALILES, et al.

Defendants-Appellants.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Robert R. Merhige, Jr., District Judge.

Upon condsideration of a motion of the appellants that the mandate be stayed pending application to the United States Supreme Court for a writ of certiorari,

IT IS ORDERED that the motion is denied.

For the Court - By Direction.

JOHN M. GREACEN
CLERK

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA RICHMOND DIVISION

THE VIRGINIA HOSPITAL ASSOCIATION, **Plaintiff,**	)	
v.	)	**Civil Action No. 86-0166-R**
GERALD L. BALILES, *et al.*, **Defendants.**	)	

ORDER

The Court is in receipt of defendants' motion for summary judgment and plaintiff's cross-motion for summary judgment on the issues raised in defendants' motion. By Order dated March 25, 1988, the Court denied defendants' motion. The Court now provides in the accompanying memorandum the reasons behind said Order. Because the disposition of defendants' motion effectively rules on plaintiff's motion, no further Order is required.

The Court finds that the disposition of defendants' motion involves controlling questions of law as to which there are substantial grounds for differences of opinion and that an immediate appeal from this Order and the Order of March 25, 1988 may materially advance the ultimate termination of the litigation. Accordingly, it is ADJUDGED and ORDERED that defendants' motion to certify issues for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) is GRANTED.

Let the Clerk send a copy of this Order and the Memorandum to counsel of record.

/s/ ROBERT R. MERHIGE, JR.
UNITED STATES DISTRICT JUDGE

Date May 18, 1988

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA RICHMOND DIVISION

THE VIRGINIA HOSPITAL ASSOCIATION, Plaintiff,	)	
v.	)	**Civil Action No. 86-0166-R**
GERALD L. BALILES, *et al.*, Defendants.	)	

MEMORANDUM

This matter came before the Court on defendants' motion to dismiss or for summary judgment. By Order dated March 25, 1988, the Court denied defendants' motion. On March 30, 1988, defendants moved to certify issues for interlocutory appeal. In order to facilitate defendants' contemplated appeal, the Court hereby states the reasons behind the March 25, 1988 Order. Jurisdiction is premised on 28 U.S.C. §§ 1331 and 1343.

Background

Plaintiff Virginia Hospital Association (VHA) is a non-profit organization whose members include Virginia hospitals. Its alleged purpose is improving the hospital industry in Virginia. Defendants are officials in the government of the Commonwealth of Virginia and include the Governor, Secretary of Human Resources, Director of Medical Assistance Services and members of the Board of Medical Assistance Services.

VHA brought this action challenging Virginia's procedures for reimbursing hospitals for costs associated with the Medicaid program ("Virginia Plan"). In Count I, plaintiff seeks a declaration that the Virginia plan violates the Medicaid Act, 42 U.S.C. § 1396 *et seq*., and therefore also violates the Supremacy Clause. In Count II, VHA seeks a declaration that the Virginia Plan violates due process. In Count III, VHA requests that the Court permanently enjoin enforcement of the Virginia Plan.

On September 22, 1986, this Court granted summary judgment for defendants on the ground that VHA was collaterally estopped from litigating issues previously decided by this Court in *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985). The Fourth Circuit reversed and remanded. *Virginia Hospital Association v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

Discussion

Defendants have moved for summary judgment on eight grounds.

I. Eleventh Amendment Bar

Defendants assert that the Eleventh Amendment to the United States Constitution bars plaintiff's claims. The Eleventh Amendment, of course, limits the type of relief that can be recovered from a state.

While the development of Eleventh Amendment jurisprudence has been complex, the Supreme Court recently has clearly delineated the scope of such immunity. In *Papasan v. Allain*, the Court explained as follows:

> Relief that in essence serves to compensate a party injured in the past by an action of a state official in his official capacity that was illegal under federal law is barred even when the state official is the named defendant. This is true if the relief is expressly denominated as damages. It is also true if the relief is tantamount to an award of damages for a past violation of federal law, even though styled as something else. On the other hand, relief that serves directly to bring an end to a present violation of federal law is not barred by the Eleventh Amendment even though accompanied by a substantial ancillary effect on the state treasury.

106 S.Ct. 2932, 2940 (1986) (citations omitted).

By the express terms of its complaint, VHA purports to seek an end to a present violation of federal law. As relief, VHA seeks to enjoin operation of the Virginia Plan in the future. The Court finds no indication of a disguised attempt to recover damages for an injury in the past. While the relief sought would have substantial ancillary effect on the state treasury, such relief is not barred by the Eleventh Amendment. Accordingly, defendants's motion for summary judgment on this ground must be denied.

II. Standing

Defendants challenge VHA's standing to bring this action. Plaintiff asserts it has representative or associational standing.

The test for associational standing is as follows:

> [A]n association has standing to bring suit on behalf of its members when:
> (a) its members would otherwise have standing to sue in their own right;
> (b) the interest it seeks to protect are germane to the organization's purpose; and
> (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.

Coles v. Havens Realty Corp., 633 F.2d 384, 390 (4th Cir. 1980) (quoting *Hunt v. Washington Apple Advertising Commission*, 432 U.S. 333 (1977)), *modified sub. nom., Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982).

Defendants do not appear to dispute the existence of the first two components. Defendants, however, assert that the nature of the case requires the participation of VHA's individual members. Defendants characterize the lawsuit as a group appeal of individual hospital reimbursement rates.

In contrast, plaintiff asserts it is challenging factors common to all of the hospitals. Accordingly, individual participation would not be required. Moreover, plaintiff seeks equitable relief, which is less likely to require individual participation than if damages were sought.

At this time, the Court is inclined to agree with plaintiff. Accordingly, defendants' motion for summary judgment on this ground must be denied. However, if at some later date the Court discovers that defendants' characterization of this suit is accurate, the Court will reconsider the issue.

III. Enforceable Right

Defendants contend that the substantive enforceable rights, if any, under the Medicaid Act are conferred on Medicaid recipients, not health care providers. Thus, while a recipient may bring an action under the Medicaid Act, *see Schweiker v. Hogan*, 457 U.S. 569 (1982), defendants contend that a health care provider may not.

The Court finds defendants' argument without merit. The Medicaid Act provides that a "State plan for medical assistance must . . . provide for payment . . . of the hospital, skilled nursing facility, and intermediate care facilities . . ." 42 U.S.C. § 1396a(a)(13)(A). Accordingly, health care providers directly and expressly benefit from the Medicaid Act.

"[C]ourts . . . permitt[ing] providers to bring actions to enforce the Medicaid statutes . . . have recognized that Medicaid patients and health-care providers have parallel interests with respect to Medicaid funding and reimbursement." *Coos Bay Care Center v. Oregon*, 803 F.2d 1060, 1063 (9th Cir. 1986), *cert. granted*, 107 S.Ct. 1970, *vacated as moot*, 108 S.Ct. 52 (1987). No significant distinction can be made between recipients and providers with respect to their ability to enforce the act. *Massachusetts General Hospital v. Sargent*, 397 F. Supp. 1056, 1059 (D. Mass. 1975).

Defendants' reliance on *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) is misplaced. In *Pennhurst*, a class of mentally retarded persons claimed they had a right to better state-funded accommodations under the Developlmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000, *et seq.* The Court examined said Act and found it spoke merely in precatory terms. *Id.* at 18. That is, providing a certain level of accommodations was not a condition to the state receiving federal funds. *Id.* at 17-18. Here, by contrast, "each state participating in the Medicaid program *must* reimburse hospitals at rates set by the state that are reasonable and adequate." *Virginia Hospital Association*, 830 F.2d at 1310 (emphasis added).

Accordingly, defendants' motion for summary judgment with respect to this issue must be denied.

IV. Foreclosure

Defendants contend that the remedial scheme provided by the Medicaid Act forecloses a private remedy under 42 U.S.C. § 1983.

"[I]f there is a state deprivation of a "right" secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright v. Roanoke Redevelopment and Housing Authority*, 107 S.Ct. 766, 771 (1987). The state actor may overcome its burden by demonstrating that the statute's remedial devices are "sufficiently comprehensive and effective to raise a clear inference that Congress intended to foreclose a § 1983 cause of action." *Id.*

Defendants cannot claim that Congress expressly foreclosed private enforcement of the Medicaid Act. Instead, defendants contend the Medicaid Act contains a comprehensive scheme of enforcement. These provisions include: a requirement that the state make assurances to the Secretary of Health and Human Services (the "Secretary") that the rates are reasonable, 42 U.S.C. § 1396a(a)(13)(A); a directive that the Secretary approve any plan that fulfills the conditions listed in the Act, 42

U.S.C. § 1396a(b); and a provision that the records of participating entitites may be audited if the Secretary finds an audit necessary, 42 U.S.C. § 1396a(a)(42).

The Court finds that these generalized powers are not sufficiently comprehensive and effective to demonstrate that Congress intended to foreclose private remedies. *Cf. Wright*, 107 S.Ct. at 773. Accordingly, defendants' motion for summary judgment on this issue must be denied.

V. Statute of Limitations

The parties agree that the relevant statute of limitations is two years. They disagree, however, over when the cause of action accrued.

Defendants assert that, since plaintiff purports to make a facial challenge to the Virginia plan, the claim accrued when the enacted scheme became effective on July 1, 1982. Plaintiff asserts that it is challenging the enactment, enforcement and implementation of the Virginia Plan. Each time its members are injured, it argues, the limitation period begins anew.

The Court agrees with plaintiff. The continued enforcement of an unconstitutional statute cannot be insulated by the statute of limitations. *See generally Brown v. Board of Education*, 347 U.S. 483 (1954); *Eldridge v. Bouchard*, 620 F. Supp. 678 (W.D. Va. 1985). Accordingly, defendants' motion for summary judgment on this ground must be denied.

Stare Decisis

Defendants correctly assert that *Mary Washington* will have a stare decisis effect on the disposition of this case. However, that cannot be grounds for dismissal at this stage of the litigation. If it were so, the limitations on the res judicata doctrine would be rendered meaningless. *See* 1B J. Moore, J. Lucas, T. Currier, Moore's Federal Practice ¶ 0.402[2] (2d ed. 1984) ("[A] [stare decisis] theory under which a judgment in one case inexorably determines the judgment in another indistinguishable on its substantive facts would confuse the principle of stare decisis with those of res judicata. Even as applied to decisions of the trial court, such a theory would result in foreclosing issues of law not raised or considered in the previous decision, though the parties to the second case are not bound by the first judgment").

Accordingly, defendants' motion for summary judgment on this issue must be denied.

VII. Ripeness

Defendants again characterize this lawsuit as a group appeal of individual rates. They assert that, since the administrative appeals have not been taken and/or finalized, this action is not ripe.

In determining whether a challenge to an administrative regulation is ripe for review, a twofold inquiry must be made. *Toilet Goods Association, Inc. v. Gardner*, 387 U.S. 158, 162 (1967). First, the Court must determine whether the issues tendered are appropriate for judicial resolution. *Id.* With regard to this factor, the Court should consider whether the questions presented are legal ones. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967). The Court might also examine whether the manner of enforcing the regulations is still speculative. *See Toilet Goods*, 387 U.S. at 162-64. Second, the Court should assess the hardship to the parties if judicial relief is denied at that stage. *Id.* at 162.

Under these tests, the Court finds that the challenge is not premature. The rate calculation regulations have been in effect for several years, so that their manner of enforcement is not speculative. Moreover, the primary allegation in the complaint is that the method used to calculate rates is legally defective—certainly, a legal question. Furthermore, if plaintiff is entitled to relief, delay causes it further hardship. Thus, both the fitness and hardship factors are present.

Defendants assert that the action is not ripe because plaintiff's members have not appealed administratively their individual rates. While defendants might prevail on this argument if this were a group appeal of individual rates, that appears not to be the case here. Plaintiff is challenging the system, not the individual rates. Again, as with the standing question, the Court may reconsider this issue if the Court later determines that defendants' characterization of the lawsuit is correct.

VIII. Abstention

Defendants urge the Court to abstain under *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943). *Buford* involved state regulation of oil and gas fields which, as the Court found, "must be regulated as a unit for conservation purposes." *Id.* at 319. Inconsistent decisions had been creating incompatable standards of behavior. *Id.* at 329-30. The state, therefore, provided a unified method of regulating this natural resource through administrative and judicial review. *Id.* at 333-34. Consequently, the Court found it appropriate to abstain.

Defendants have not convinced the Court that abstention is appropriate here. The state has not developed a comprehensive regulatory scheme that would address plaintiff's challenges. *Cf. Wright*, 107 S.Ct. at 773. If the issues cannot be raised in the state administration procedure, there is no need to abstain. *Curtis v. Taylor*, 648 F.2d 946,

949 (5th Cir. 1980). Moreover, by enacting the Medicaid Act, the federal government has determined that this is not solely a state concern.

Accordingly, summary judgment on this ground will be denied.

An appropriate Order shall issue.

/s/ ROBERT R. MERHIGE, JR.

UNITED STATES DISTRICT JUDGE

Date May 18 1988